City of Long Beach
DEPARTMENT OF HUMAN RESOURCES

CERTIFICATE OF MEDICAL DISABILITY

TO BE COMPLETED BY PHYSICIAN

The use of sick leave and/or temporary disability leave may only be granted to an employee who provides acceptable verification of illness or incapacity. Please help us by completing this form as thoroughly and accurately as possible. Your signature indicates the following information is correct.

I certify that (name) _____ is currently a patient under my care. I examined this patient on _____ (dates). He/she has been receiving treatment for this disability beginning _____ (date).

He/she is expected to be disabled from _____ to _____.

The next scheduled examination of this patient is _____ (date).

If the patient cannot return to full duty, but could return to light duty with some work limitations, please specify those limitations in detail. (A Classification Specification for the employee's current position is attached.)

I further certify that if subsequent medical examination(s) of this patient reveals facts that would result in a change in any of the facts or opinions expressed herein, I will notify this patient and will also notify the Long Beach Department of Health and Human Services, 2525 Grand Avenue, Long Beach, CA 90815, (562) 570-4051.

(PLEASE PRINT OR TYPE)

_____
Physician's Name

_____
Physician's Signature **Date**

_____
Title

_____
Address

_____
City/State **Zip Code**

(_____) _____
Telephone Number

Original : Department of Health and Human Services
cc: Departmental File